AFFORDABILITY OF MEDICARE AND A PRESCRIPTION DRUG BENEFIT

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Hearing On:

"Medicare and the Federal Budget"

Committee on the Budget

U.S. House of Representatives

May 8, 2002

[1] The views expressed in this paper do not represent those of Georgetown or George Washington University.

Chairman Nussle, Congressman Spratt, and distinguished Committee Members, thank you for the opportunity to offer this testimony about Medicare and the Federal budget. My goal today is to remind you that Medicare is one of our nation's greatest achievements and that, as a nation, we have both the obligation and capacity to sustain and extend that achievement to provide affordable health insurance—including prescription drugs—to seniors and to people with disabilities.

Medicare Works

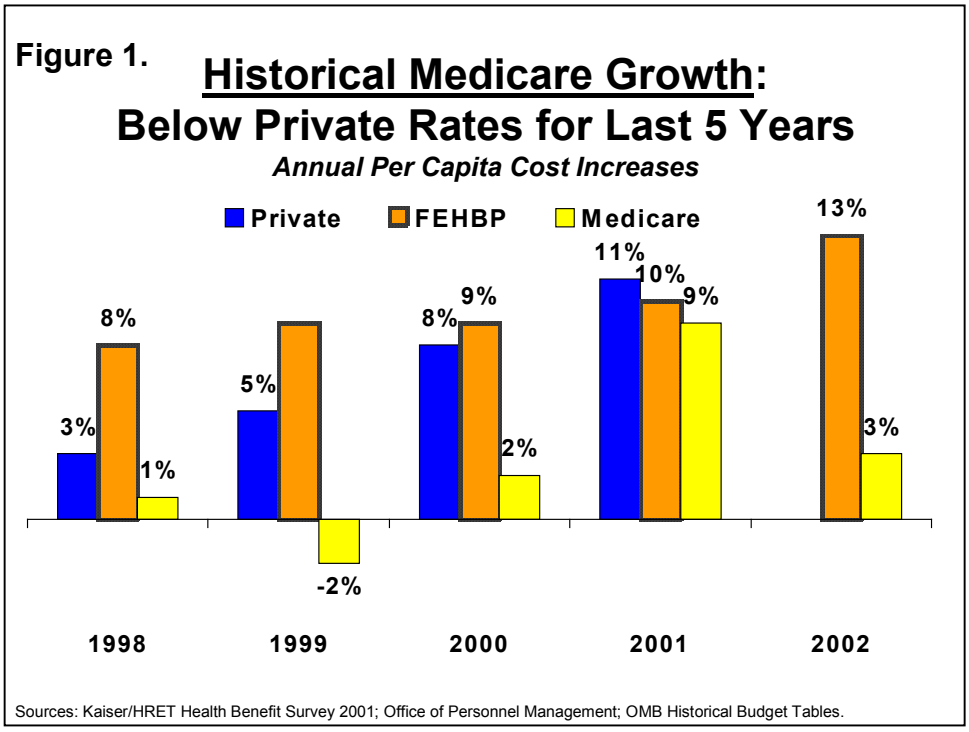
The issue of Medicare reform is neither new nor simple. Defining Medicare's problems, let alone coming to consensus over solutions, has been controversial. Discussions of Medicare and the federal budget often define the "problem" as the gap between projected payroll tax revenues and health care spending that will result from the aging of the population. An all-too-common reaction is to declare Medicare fiscally "unsustainable" and to call for a retraction of government responsibilities for the health care of the elderly. But this approach obscures the real challenge of an aging population and ignores Medicare's fundamental purpose.

For more than 30 years, Medicare—with some significant help from Medicaid for low-income elderly and for long-term care—has provided affordable health insurance of the nation's elderly citizens without the problems that plague health insurance for younger Americans. Medicare is nearly universal, avoids dividing the healthy from the sick and the poor from the better-off, and provides reliable coverage with a choice of providers.

Limiting the government's liabilities for health care will not make those liabilities go away. Rather, it will shift them back to elderly, people with disabilities and their families. And Medicare's signal advantages—its ability to spread risk and to make insurance affordable—will be lost. That is not solving the problem; it is abdicating responsibility. Instead our goal should be to assure that Medicare has adequate financing to provide effective health insurance in the future as it does today.

Our ability to achieve that goal is enhanced by Medicare's fiscal performance. Health care is expensive. But Medicare is as good and often better than the private sector in managing cost growth. Faced with high rates of expenditure growth and trust fund problems in the 1990s, policy makers responded with payment rate changes that dramatically slowed Medicare cost growth. In the past 5 years, Medicare's average growth rate per beneficiary was significantly lower than that of the private sector or the Federal Employees' Health Benefits Plan (FEHBP) (Figure 1).

Figure 1.

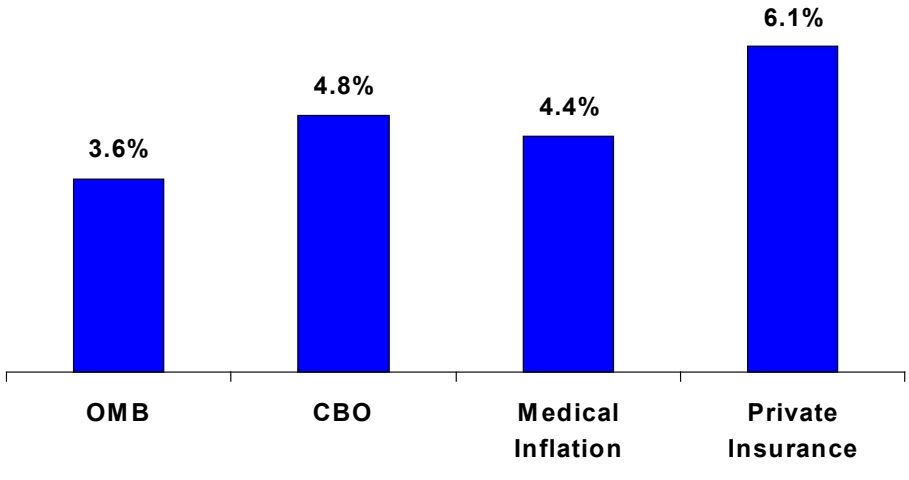


Although the cost of health care is an issue for the entire nation (not Medicare alone) and there will always be controversy about whether Medicare is paying too much or too little, recent experience demonstrates that policymakers have the tools they need to manage Medicare's costs.

The Medicare baseline projections for the next 10 years recognize the effectiveness of these tools for the future as well as the past. Both the Congressional Budget Office (CBO) and the Office of Management and Budget (OMB) are projecting average Medicare growth rates per beneficiary that are low: 4.8 and 3.6 percent for the next 10 years[1] -- at or below medical inflation (4.4 percent from March 2001 through 2002) and well below projected private premium growth projections (6.1 percent for 2002 through 2010) (Figure 2). Medicare has not grown this slowly for any past 10-year period.[2] Similarly, in its most recent report, the Medicare Trustees project that the Hospital Insurance Trust Fund will be solvent through 2030. Few previous Trustees' projections have been more optimistic than this.

Figure 2. **Projected Medicare Spending: Low Relative to Private Growth**

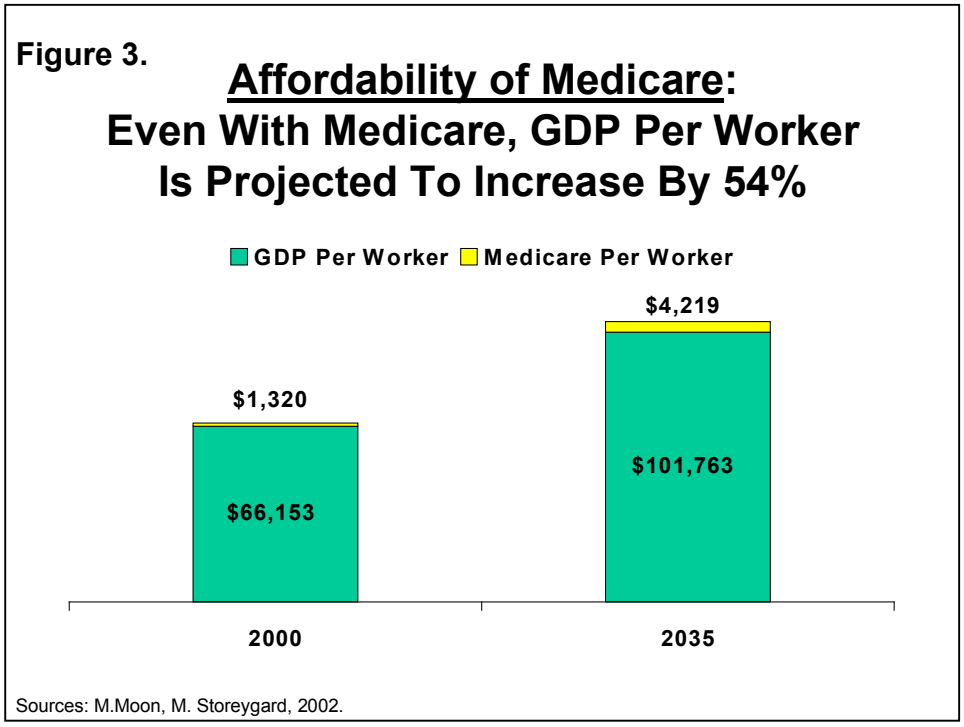
Average Annual Per Capita Cost Increases, 2003-12*



Sources: President's Budget; CBO March 2002 Baseline; Bureau of Labor Statistics, CMS Nat'l Health Accounts March 2002.
* Note that the Medical inflation amount is historical (From March 2001-2002) and private premiums is for 2003-2011 due to data limits.

Our ability to support the Medicare program goes well beyond the strength of the Trust Fund. Most critical to that support is the strength of our economy. A recent analysis by Marilyn Moon suggests how important it is to examine projected Medicare cost growth in the context of overall economic growth. Her analysis demonstrates that future taxpayers will be substantially better off than current taxpayers, even taking Medicare cost growth into account. By her estimates, GDP per worker will rise by 53.8 percent between 2000 and 2035, even taking into account Medicare spending projections. Without Medicare, this projected increase in GDP per worker would be 57 percent (Figure 3). Stated simply, this nation's economy will likely grow strongly enough to pay for Medicare beneficiaries' future health care costs.[3]

Figure 3.



Sources: M.Moon, M. Storeygard, 2002.

A Prescription Drug Benefit Is Medicare's Most Pressing Need

Medicare's biggest challenge is not better managing what it already covers; instead, it is covering what it currently excludes: prescription drugs. Prescription drugs have become an

integral part of modern medicine, often preventing disease, managing chronic illness and even curing certain conditions. Seniors and people with disabilities disproportionately rely on prescription drugs. According to recent CBO testimony, Medicare beneficiaries account for 15 percent of the population but 40 percent of the spending on outpatient prescription drug spending. The average Medicare beneficiary will spend over $2,400 on prescription drugs next year, and nearly one in five beneficiaries (17%) are expected to spend more than $5,000 by 2005. Over the next decade, Medicare beneficiaries are projected to spend $1.8 trillion on prescription drugs – with or without a Medicare drug benefit.[4]

Not only do Medicare beneficiaries have a greater need for prescription drugs; they also disproportionately lack coverage for it. Depending on how one counts, anywhere from 25 to 42 percent of Medicare beneficiaries lack prescription drug coverage for all or part of the year.[5] This problem is worse for older and rural beneficiaries. Over time, most experts suggest that the proportion of beneficiaries who lack drug coverage will grow as the cost of Medigap policies with drug coverage rises, the drug benefits in Medicare managed care plans become less generous and more scarce, and employers continue to cut back on retiree health coverage.

A Prescription Drug Benefit is Affordable

There is a widespread consensus on the need for a Medicare prescription drug benefit. What is lacking is agreement on what constitutes an adequate benefit—the distribution of prescription drug costs between seniors and taxpayers –, its affordability, and its priority.

Substantial differences exist in the scope of proposed prescription drug benefits. This Committee allocated $350 billion over 10 years for a benefit; the Senate Budget Committee allocated $500 billion. And it would cost an estimated $750 billion over 10 years to provide seniors with a benefit comparable to the benefit members of Congress receive through the Federal Employees Health Benefits Program.

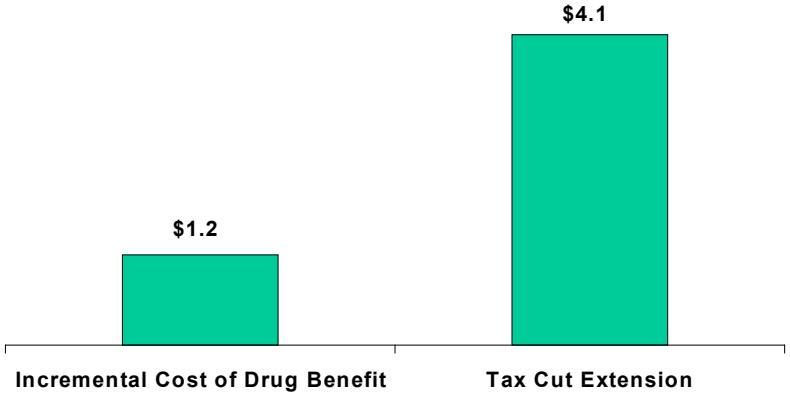
Recently, Administration testimony implied that the nation cannot afford a $750 billion drug benefit: "The excess costs of $400 billion in the first 10 years would balloon to $1.2 trillion in the next ten, just when the Baby Boomers are counting on Medicare." The testimony continues to claim that a drug benefit of this size would, by 2030, be "equivalent to a tax of $2,170 (in today's dollars) on every working American."[6]

But, the Administration's analysis suggests that its concern is not affordability, it is priorities. In fact, combining what the President's budget spends on Medicare and its tax cuts, the budget already includes $750 billion that could be applied fully to a Medicare drug benefit.[7] Moreover, in the second decade, the extension of the tax cut would cost, according to the Center on Budget and Policy Priorities[8], $4.1 trillion, compared to the Administration's estimated $1.2 trillion cost of the additional amount of drug coverage (Figure 4). And, it is not until well after 2020 that the cost per worker of a drug benefit exceeds that of the cost per worker of a tax cut, according to a forthcoming analysis by the Center on Budget and Policy Priorities; in 2020, the average tax cut cost per worker ($1,579 in 2002 dollars) would still exceed that of the cost per worker of the entire $750 billion drug benefit ($1,064). Thus, it is hard to reconcile the claimed priority given to a prescription drug benefit with the proposal to eliminate the revenues needed to support it.

Figure 4. **What Is The Priority?**

Out-Year Cost of Prescription Drug Benefit and Tax Cut Extension

(Dollars in Trillions, FY 2013-22)



Sources: M. McClellan, House Energy & Commerce Committee, 4/17/02; Center on Budget and Policy Priorities.

On the source of funding, the Administration has challenged the use of both the Hospital Insurance Trust Fund and general revenue financing. Specifically, it claims that funding a prescription drug benefit from the Trust Fund would cut its insolvency in half, and that funding it through a mechanism like the Supplemental Medical Insurance Trust Fund represents "accounting gimmicks."[9] Corroborating this concern, the Administration omitted general revenue funding from its displays of the current Medicare program's financial health in its budget documents, despite its legal, 35-year history of supporting Part B services. On prescription drug financing, no one has proposed the first, and the Administration itself has used the second. General revenue funding supports outpatient services in Medicare today; it is a more progressive way to finance benefits than a payroll tax increase; and, while weakened, the budget outlook is strong enough to support this use of funds. The fact that the Administration's own $190 billion Medicare allocation is drawn from general revenues raises the question of where and, more importantly, why the Administration is drawing lines about legitimacy of the funding of this critical benefit.

CONCLUSION

The facts suggest that the biggest challenge facing Medicare today is not its cost growth or even its long-term affordability but its lack of a prescription drug benefit. Medicare has contributed and will, in the immediate future, continue to contribute to longer and healthier lives for our nation's elderly. But its historical protection of seniors against the economic consequences of high health care costs is now threatened by rising drug costs and its lack of a drug benefit. By 2012, Medicare beneficiaries are projected to spend more on prescription drugs than Medicare is projected to spend on all Part B services combined, according to CBO. A $750 billion prescription drug benefit would cover less than half of prescription drug costs of Medicare beneficiaries. It costs far less, over time, than the extension of the tax cut. The question here is not affordability, it is priorities.

Notes:

[1] From Crippen DL. (March 7, 2002). *Projections of Medicare and Prescription Drug Spending*. Testimony before the Committee on Finance, U.S. Senate. Washington, DC: Congressional Budget Office. Assumes projected beneficiary growth of 1.7% over the 2003-12 period.
[2] Reischauer R. (March 2002). Presentation at the American Enterprise Institute.
[3] Moon M, Storeygard M. (March 2002). *Solvency or Affordability? Ways to Measure Medicare's Financial Health*. Menlo Park, CA: The Henry J. Kaiser Family Foundation.
[4] Crippen, 2002.
[5] CBO defines uninsured as lacking drug coverage throughout the year (25%); Laschober MA, Kitchman M, Neuman P, Stabic AA. "Trends in Medicare supplemental insurance and prescription drug coverage, 1996-1999," *Health Affairs*. February 27, 2002, Web Exclusive, pp. W127-W138 define coverage as point in time (38%); and Briesacher B, Stuart B, Shea D. *Drug Coverage for Medicare Beneficiaries: Why Protection May be in Jeopardy.* New York (NY), The Commonwealth Fund, January 2002 define it as the number who lack drug coverage for part or all of the year (42%).
[6] McClellan M. (April 17, 2002). "Creating a Medicare Prescription Drug Benefit: Assessing Efforts to Help America's Low-Income Seniors." Testimony before the Committee on Energy and Commerce, U.S. House of Representatives. Washington, DC: White House Council of Economic Advisors.
[7] The President's budget includes $603 billion for tax cuts and $169 billion for Medicare for FY 2003-12, according to CBO's Analysis of the President's Budget.
[8] Friedman J; Greenstein R; Kogan R. (April 16, 2002). *The Administration's Proposal to Make the Tax Cut Permanent*. Washington, DC: Center on Budget and Policy Priorities.
[9] McClellan, 2002.